WHERE DO WE GO FROM HERE?*

BRUCE C. VLADECK, PH.D.
President
United Hospital Fund
New York, New York

THERE ARE FOUR POINTS I would like to make that, when taken together, will offend just about everybody remaining in the audience. Some of these points have already been made in passing, but I think they are worth further emphasis.

First, as an outsider to the whole world of medical education, one of the things that one thinks about in sitting through a day like today, in summarizing the events of the last 18 months, is whether at root the 405 Regulations are basically a good idea or not. I am struck by the number of people who think that it is an excellent idea and then say "but.... " Nonetheless, I am prepared to say that, probably on balance, the changes made, or that were proposed to be made, in graduate medical education were probably a good thing. I think that there is a degree of consensus about that. I think there is also an interesting implicit consensus that is not recognized as such between the Health Department and the program directors. The program directors are saying we have to be flexible in interpreting the regulations, and the Health Department is saying, as loudly as it can without violating its legal obligations, "we are, we are," and neither side is acknowledging what the other is saying.

Having said that, I believed a year and a half ago, and I believe even more strongly now, that there is a broader public policy question at issue, which we have not talked about today. That is, whether or not the implementation of the 405 Regulations costs 200 million dollars or 300 million dollars a year—and, I should point out, will cost that much plus inflation every year in the future and whether or not these are inherently good things to do, as I suspect the consensus is. I would raise the question of whether at this point in our history, with the other strains and demands and priorities on the health care system in the State of New York, it is sound public policy to spend 400 million dollars

*Presented as part of a *Conference on Regulation of Residency Training: An Appraisal of Recent Changes* held by the Associated Medical Schools of New York, the Committee on Medical Education of The New York Academy of Medicine, and the United Hospital Fund of New York November 28, 1990.

or even 200 million dollars on this instead of on all the other things on which it could be spent? Now each of us will have his own laundry list of preferred expenditures. Mine would probably have something to do with providing primary care services to 150,000 HIV-infected people walking around in this city outside the health care system altogether, but the point of my question is that there are many possible places we could use the money.

We could argue where the money should go, but I think it would be hard to make the case that funds should go first to a reform of graduate medical education, even to the extent that one argues at the same time that it produces measurable improvement in the quality of care rendered to patients in the state's hospitals. And it will be years before we know whether or not care has improved at all. I think one can ask what it tells us about the system's sense of priorities that that is where we are spending our money at a time when there are so many other things on which we are not spending our money.

The second point I would like to make has been referred to by several speakers, including Dr. Axelrod during questions. I listened very sympathetically much of the day to all the discussions of continuity and the disturbance or destruction of continuity in the residency experience by the new regulation until it occurred to me, rather late this afternoon, that the model of continuity we were talking about has nothing to do with my experience of how practicing physicians actually practice medicine in the United States at this point in the 20th century.

In fact, most of the middle class women I know who delivered babies in the last six years, who were private-pay patients have been cared for by obstetrical groups, for example, without the foggiest idea of who would actually be with them in the delivery room until the obstetrician arrived. The one wonderful solo-practitioner pediatrician who has been my kids' pediatrician all of their lives, and whom we think is absolutely the model of private continuity of care to which everyone aspires, in fact, as he ages, spends more and more of his time in Florida, and we never know who is covering for him when he is away. So I wonder how meaningful the romantic notion of continuity of care in real medical practices is in terms of its value when we talk about residency programs.

It seems to me that if we do not have continuity in terms of individuals responsible for every aspect of patients' care during the course of hospitalization, then the substitute for that needs to be some kind of effective teamwork among the physicians responsible for the patient's care, as is done in good group practices, as is also done in good institutional settings of one sort or another. Therefore, both Drs. Kase and Bell, having described the issue in

very different ways, are entirely right. If we are going to make the 405 Regulations the basis for some sensible model of training in continuity, particularly in the outpatient setting, we are going to have to rethink the way in which house staff, attendings, medical students, nurses, and other health professionals involved in the care of a group of patients work with one another. We are also going to have to think about how firms or teams, or groups, or whatever we want to call them, communicate, how they interact, how they share information, and how they share values.

My third point deals with the latent subtext in all our discussions today. Again, Dr. Bell hinted very indirectly that in the City of New York and a number of other major cities in the United States, we take care of poor people by using house staff. The more one examines that basic model of health services delivery, the more ridiculous it is from the point of view of both the patient and the house staff. The fact that this has been the primary mechanism for delivering medical care to poor people in this city for the last 100 years or so is no excuse, as it were, to accept that it always has to be that way. Yet, the arguments for and against both the specifics of the 405 Regulations and specific issues of implementation fail, it seems to me, to grapple directly with the far more fundamental issue of how we are going to redesign our system of inner-city primary care to reduce the dependence of poor people and house staff on each other.

Finally, when I was returning to New York from a brief stint at The Robert Wood Johnson Foundation, one of my colleagues there reminded me that in the United States there are something like 4,000 general hospitals with no house staff at all, and somehow some fraction of those hospitals continues to provide reasonably decent patient care. In fact, a number of them provide cardiac catherization and increasingly sophisticated surgical procedures, do all the most advanced diagnostic imaging, and so forth. Of course, half of those 4,000 hospitals have fewer than 100 beds. But, nonetheless, the amazing fact is that it is at least conceptually possible to provide inpatient hospital care to the great bulk of hospital inpatients who do not require the most sophisticated services without any house staff at all. This is not a notion with which we can even begin to deal, given the way we have organized hospital services and medical practice in the City of New York. But I would suggest that we at least think about it as a mental exercise to suggest some of the questions we have to ask ourselves for the future about the relationship between graduate medical education and service and about where some of these pressures will be pulling us in the future.